MEDI-CAL ANNUAL REDETERMINATION FORM

You must fill out this form and return it to the county to keep your Medi-Cal!

Case number ***(optional)***	**Social security number** ***(optional)***	
Print your name *(If you have not moved, put address label here if one is provided.)*	**Birth date** ***(optional)*** **(mm/dd/yyyy)**	
Current street address, apartment number ☐ *Check here if address is new*	**City**	**ZIP code**
Mailing Address, **if different from above**	**City**	**ZIP code**

Use ink and **PRINT** your answers. If you have any questions or need help filling out this form, call your worker at the telephone number listed on the Annual Redetermination Notice. Make sure you sign and date the form.

Use the postage paid envelope to return it. If you need more space, attach a separate sheet to this form.

Section 1. Income

(a) Do you or any family member in the home get money from a job, child support or alimony, social security, veteran benefits, unemployment or disability benefits, retirement, gifts, or interest or dividends? ☐ Yes ☐ No
If yes, complete below and list each source of income on a separate line.

Attach most recent pay stubs showing income before taxes or deductions, benefit or award letters, checks received or signed statement from employer, or last year's federal income tax return. If income is from self-employment, send a copy of your most recent tax return or profit and loss statement.

Name of Person With Income	Source of Income	Income Amount (before any deductions)	How Often Paid (weekly, monthly, twice a month)	Hours Worked (per week or month)

(b) Do you or any family member in the home get rent, utilities, food, or clothing entirely free? ☐ Yes ☐ No

If yes, who? _____ What was free? _____

(c) Was the free rent, utilities, food, or clothing received in exchange for work done? ☐ Yes ☐ No

Section 2. Expenses and Deductions

Do you or any family member in the home pay for child or adult care, health insurance or Medicare premiums, court-ordered child support or alimony, or educational expenses? ☐ Yes ☐ No
If yes, complete below and list each expense/deduction on a separate line.

Attach proof of expenses/deductions.

Name of Person with Expense/Deduction	Type of Expense Or Deduction	Amount of Payment	Paid to Whom	How Often Paid (weekly, monthly, twice a month)

Section 3. Other Health Insurance

(a) Did you or any family member have a change in, or get new health, dental, vision, or Medicare coverage or insurance within the last 12 months? ☐ Yes ☐ No

If yes, who has the coverage/insurance? _____

Which type of coverage/insurance? _____

(b) Is any family member living in the home receiving kidney dialysis-related services? ☐ Yes ☐ No

If yes, who? _____

Section 4. Living Situation

(a) Did anyone move into or out of your home, move in with someone else, get married, or have a baby within the last 12 months? *(Examples: newborn, child, or adult moved in or out of the home, absent parent returns home.)* ☐ Yes ☐ No

If yes, complete *below*.

Name	Relationship to you	Want Medi-Cal?	What Changed?	Date Changed
		☐ Yes ☐ No		
		☐ Yes ☐ No		

(b) If a new baby is in the home, where was the baby's place of birth? _____ / _____
City Country

(c) Did anyone in the home get inpatient care in a nursing facility or medical institution? ☐ Yes ☐ No

If yes, who? _____

(d) Is anyone in the home pregnant? ☐ Yes ☐ No

If yes, who? _____ Expected date of delivery: _____

Section 5. Real or Personal Property

(a) Indicate the total amount of cash and uncashed checks held by any family member in the home: $_____

(b) Does anyone have a checking or savings account, life insurance, long-term care insurance, motor vehicle, court-ordered settlement or judgment, stocks, bonds, retirement funds, trusts where money or property is held for the benefit of any family member in the home, real estate, motor vehicles for a business, business accounts or property, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), or oil or mineral rights? ☐ Yes ☐ No

(c) Did you or any family member in the home sell or give away any money or property in the past 12 months, or have any of the items listed in this section been spent or used as security for medical costs? ☐ Yes ☐ No

If you have answered "yes" to questions (b) or (c), you will also have to fill out a property supplement form.

Section 6. Immigration or Citizenship Status Change

Has there been a change in immigration or citizenship status for anyone in the home that has Medi-Cal or wants Medi-Cal within the last 12 months? *(If your immigration status has changed, you might qualify for full scope Medi-Cal benefits.)* ☐ Yes ☐ No

If yes, list the name(s) below and send proof of new status.

Name(s): _____

Section 7. Blindness/Disability/Incapacity

(a) Do you or any family member in the home have a physical or emotional condition that makes it difficult to work, take care of personal needs, or take care of your children? ☐ Yes ☐ No

If yes, who? _____

(b) Was the physical, mental, or health condition a result of an injury or accident? ☐ Yes ☐ No

If yes, explain? _____

_____

Section 8. Other Health Program Information and Referrals

(a) Check this box if you do **not** want your child's information shared with the low-cost Healthy Families Program if your child gets Medi-Cal with a share of cost. ☐

(b) Do you want information on the no-cost health program for children under 21 *(Child Health and Disability Prevention Program, also known as CHDP)*? ☐ Yes ☐ No

(c) Do you want information on the no-cost supplemental food program for pregnant or breastfeeding women and children under 5 *(Women, Infants, and Children Program, also known as WIC)?* ☐ Yes ☐ No

(d) Do you want information on the Personal Care Services Program, an in-home care program for aged, blind, or disabled persons (also known as In-Home Supportive Services)? ☐ Yes ☐ No

CERTIFICATION—Person completing this form must read and sign below.

- I have received and read a copy of the Important Information for Persons Requesting Medi-Cal form (MC 219).
- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 219 form.
- I certify that I will report all income, property, and/or other changes that may affect Medi-Cal eligibility within ten days of the change.
- I understand that all of the statements, including benefit and income information, that I have made on this form, may be subject to investigation and verification.
- I declare, under penalty of perjury, under the laws of the State of California that all information provided on this form is true and correct.

Signature	**Date**

Daytime or Message Telephone Number	**Home Telephone Number** ☐ *Check here if new number*

Signature of Witness (if signed by a mark), Interpreter or Person Assisting

—County Use Only—

Worker Signature	**Worker Number**	**Date Annual Completed**

Referrals		**Follow-up Forms**		
☐ HF	☐ WIC	☐ DHS 6155	☐ MC 210 PS	☐ Other: _____
☐ CHDP	☐ PCSP	☐ MC 13	☐ DAPD Packet	_____